

Senate Amendment 3276

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1 1 Amend House File 667, as amended, passed, and
1 2 reprinted by the House, as follows:
1 3 #1. Page 9, by inserting after line 15 the
1 4 following:
1 5 _____. Section 509.3, subsections 5, 6, and 7,
1 6 Code 2003, are amended to read as follows:
1 7 5. A provision shall be made available to
1 8 policyholders, under group policies covering vision
1 9 care services or procedures, for payment of necessary
1 10 medical or surgical care and treatment provided by an
1 11 optometrist licensed under chapter 154 if the care and
1 12 treatment are provided within the scope of the
1 13 optometrist's license and if the policy would pay for
1 14 the care and treatment if the care and treatment were
1 15 provided by a person engaged in the practice of
1 16 medicine or surgery as licensed under chapter 148 or
1 17 150A. The provision shall also guarantee that any
1 18 care or treatment provided by an optometrist shall be
1 19 compensated at the same level as equivalent services
1 20 provided by a person licensed in the practice of
1 21 medicine and surgery under chapter 148 or 150A. The
1 22 policy shall provide that the policyholder may reject
1 23 the coverage or provision if the coverage or provision
1 24 for services which may be provided by an optometrist
1 25 is rejected for all providers of similar vision care
1 26 services as licensed under chapter 148, 150A, or 154.
1 27 This subsection applies to group policies delivered or
1 28 issued for delivery after July 1, 1983, and to
1 29 existing group policies on their next anniversary or
1 30 renewal date, or upon expiration of the applicable
1 31 collective bargaining contract, if any, whichever is
1 32 later. This subsection does not apply to blanket,
1 33 short-term travel, accident only, limited or specified
1 34 disease, or individual or group conversion policies,
1 35 or policies designed only for issuance to persons for
1 36 coverage under Title XVIII of the Social Security Act,
1 37 or any other similar coverage under a state or federal
1 38 government plan.
1 39 6. A provision shall be made available to
1 40 policyholders under group policies covering diagnosis
1 41 and treatment of human ailments for payment or
1 42 reimbursement for necessary diagnosis or treatment
1 43 provided by a chiropractor licensed under chapter 151,
1 44 if the diagnosis or treatment is provided within the
1 45 scope of the chiropractor's license and if the policy
1 46 would pay or reimburse for the diagnosis or treatment
1 47 by a person licensed under chapter 148, 150, or 150A
1 48 of the human ailment, irrespective of and disregarding
1 49 variances in terminology employed by the various
1 50 licensed professions in describing the human ailment
2 1 or its diagnosis or its treatment. The provision
2 2 shall also guarantee that any care or treatment
2 3 provided by a chiropractor shall be compensated at the
2 4 same level as equivalent services provided by a person
2 5 licensed in the practice of medicine and surgery under
2 6 chapter 148 or 150A. The policy shall provide that
2 7 the policyholder may reject the coverage or provision
2 8 if the coverage or provision for diagnosis or
2 9 treatment of a human ailment by a chiropractor is
2 10 rejected for all providers of diagnosis or treatment
2 11 for similar human ailments licensed under chapter 148,
2 12 150, 150A, or 151. A policy of group health insurance
2 13 may limit or make optional the payment or
2 14 reimbursement for lawful diagnostic or treatment
2 15 service by all licensees under chapters 148, 150,
2 16 150A, and 151 on any rational basis which is not
2 17 solely related to the license under or the practices
2 18 authorized by chapter 151 or is not dependent upon a
2 19 method of classification, categorization, or
2 20 description based directly or indirectly upon
2 21 differences in terminology used by different licensees
2 22 in describing human ailments or their diagnosis or
2 23 treatment. This subsection applies to group policies
2 24 delivered or issued for delivery after July 1, 1986,

2 25 and to existing group policies on their next
2 26 anniversary or renewal date, or upon expiration of the
2 27 applicable collective bargaining contract, if any,
2 28 whichever is later. This subsection does not apply to
2 29 blanket, short-term travel, accident-only, limited or
2 30 specified disease, or individual or group conversion
2 31 policies, or policies under Title XVIII of the Social
2 32 Security Act, or any other similar coverage under a
2 33 state or federal government plan.

2 34 7. A provision shall be made available to
2 35 policyholders, under group policies covering hospital,
2 36 medical, or surgical expenses, for payment of covered
2 37 services determined to be medically necessary provided
2 38 by registered nurses certified by a national
2 39 certifying organization, which organization shall be
2 40 identified by the Iowa board of nursing pursuant to
2 41 rules adopted by the board, if the services are within
2 42 the practice of the profession of a registered nurse
2 43 as that practice is defined in section 152.1, under
2 44 terms and conditions agreed upon between the insurer
2 45 and the policyholder, subject to utilization controls.

2 46 The provision shall also guarantee that any care or
2 47 treatment provided by registered nurses shall be
2 48 compensated at the same level as equivalent services
2 49 provided by a person licensed in the practice of
2 50 medicine and surgery under chapter 148 or 150A. This

3 1 subsection shall not require payment for nursing
3 2 services provided by a certified nurse practicing in a
3 3 hospital, nursing facility, health care institution,
3 4 physician's office, or other noninstitutional setting
3 5 if the certified nurse is an employee of the hospital,
3 6 nursing facility, health care institution, physician,
3 7 or other health care facility or health care provider.
3 8 This subsection applies to group policies delivered or
3 9 issued for delivery in this state on or after July 1,
3 10 1989, and to existing group policies on their next
3 11 anniversary or renewal dates, or upon expiration of
3 12 the applicable collective bargaining contract, if any,
3 13 whichever is later. This subsection does not apply to
3 14 blanket, short-term travel, accident only, limited or
3 15 specified disease, or individual or group conversion
3 16 policies, policies rated on a community basis, or
3 17 policies designed only for issuance to persons for
3 18 eligible coverage under Title XVIII of the federal
3 19 Social Security Act, or any other similar coverage
3 20 under a state or federal government plan.

3 21 Sec. _____. Section 509.3, Code 2003, is amended by
3 22 adding the following new subsection:

3 23 NEW SUBSECTION. 8. A provision shall be made
3 24 available to policyholders, under group policies
3 25 covering hospital, medical, or surgical expenses for
3 26 payment of necessary medical or surgical care and
3 27 treatment, as well as drug prescriptions, provided by
3 28 a person licensed to practice podiatry under chapter
3 29 149, if the care and treatment are provided within the
3 30 scope of the person's license and if the policy would
3 31 pay for the care and treatment if the care and
3 32 treatment were provided by a person engaged in the
3 33 practice of medicine and surgery as licensed under
3 34 chapter 148 or 150A. The provision shall also
3 35 guarantee that any medical or surgical services
3 36 provided by a podiatrist shall be compensated at the
3 37 same level as equivalent services provided by a person
3 38 licensed in the practice of medicine or surgery under
3 39 chapter 148 or 150A. The policy shall provide that
3 40 the policyholder may reject the coverage or provision
3 41 if the coverage or provision for similar services
3 42 which may be provided by a podiatric physician is
3 43 rejected for all providers of services as licensed
3 44 under chapter 148, 149, or 150A. This subsection
3 45 applies to group policies delivered or issued for
3 46 delivery on or after July 1, 2003, and to existing
3 47 group policies on their next anniversary or renewal
3 48 date, or upon expiration of the applicable collective
3 49 bargaining contract, if any, whichever is later. This
3 50 subsection does not apply to blanket, short-term
4 1 travel, accident only, limited or specified disease,
4 2 or individual or group conversion policies, or
4 3 policies designed only for issuance to persons for
4 4 coverage under Title XVIII of the federal Social
4 5 Security Act, or any other similar coverage under a

4 6 state or federal government plan.
4 7 Sec. _____. Section 509.3, unnumbered paragraph 2,
4 8 Code 2003, is amended to read as follows:
4 9 In addition to the provisions required in
4 10 subsections 1 through 7 8, the commissioner shall
4 11 require provisions through the adoption of rules
4 12 implementing the federal Health Insurance Portability
4 13 and Accountability Act, Pub. L. No. 104-191.
4 14 Sec. _____. Section 514B.1, subsection 5, paragraphs
4 15 b, c, and d, Code 2003, are amended to read as
4 16 follows:
4 17 b. The health care services available to enrollees
4 18 under prepaid group plans covering vision care
4 19 services or procedures, shall include a provision for
4 20 payment of necessary medical or surgical care and
4 21 treatment provided by an optometrist licensed under
4 22 chapter 154, if performed within the scope of the
4 23 optometrist's license, and the plan would pay for the
4 24 care and treatment when the care and treatment were
4 25 provided by a person engaged in the practice of
4 26 medicine or surgery as licensed under chapter 148 or
4 27 150A. Additionally, any optometric medical or
4 28 surgical care and treatment provided shall be
4 29 compensated at the same level as equivalent services
4 30 provided by a person licensed in the practice of
4 31 medicine or surgery under chapter 148 or 150A. The
4 32 plan shall provide that the plan enrollees may reject
4 33 the coverage for services which may be provided by an
4 34 optometrist if the coverage is rejected for all
4 35 providers of similar vision care services as licensed
4 36 under chapter 148, 150A, or 154. This paragraph
4 37 applies to services provided under plans made after
4 38 July 1, 1983, and to existing group plans on their
4 39 next anniversary or renewal date, or upon the
4 40 expiration of the applicable collective bargaining
4 41 contract, if any, whichever is the later. This
4 42 paragraph does not apply to enrollees eligible for
4 43 coverage under Title XVIII of the Social Security Act
4 44 or any other similar coverage under a state or federal
4 45 government plan.
4 46 c. The health care services available to enrollees
4 47 under prepaid group plans covering diagnosis and
4 48 treatment of human ailments, shall include a provision
4 49 for payment of necessary diagnosis or treatment
4 50 provided by a chiropractor licensed under chapter 151
5 1 if the diagnosis or treatment is provided within the
5 2 scope of the chiropractor's license and if the plan
5 3 would pay or reimburse for the diagnosis or treatment
5 4 of human ailment, irrespective of and disregarding
5 5 variances in terminology employed by the various
5 6 licensed professions in describing the human ailment
5 7 or its diagnosis or its treatment, if it were provided
5 8 by a person licensed under chapter 148, 150, or 150A.
5 9 Additionally, any diagnosis and treatment provided by
5 10 a chiropractor shall be compensated at the same level
5 11 as equivalent services provided by a person licensed
5 12 in the practice of medicine or surgery under chapter
5 13 148 or 150A. The plan shall also provide that the
5 14 plan enrollees may reject the coverage for diagnosis
5 15 or treatment of a human ailment by a chiropractor if
5 16 the coverage is rejected for all providers of
5 17 diagnosis or treatment for similar human ailments
5 18 licensed under chapter 148, 150, 150A, or 151. A
5 19 prepaid group plan of health care services may limit
5 20 or make optional the payment or reimbursement for
5 21 lawful diagnostic or treatment service by all
5 22 licensees under chapters 148, 150, 150A, and 151 on
5 23 any rational basis which is not solely related to the
5 24 license under or the practices authorized by chapter
5 25 151 or is not dependent upon a method of
5 26 classification, categorization, or description based
5 27 upon differences in terminology used by different
5 28 licensees in describing human ailments or their
5 29 diagnosis or treatment. This paragraph applies to
5 30 services provided under plans made after July 1, 1986,
5 31 and to existing group plans on their next anniversary
5 32 or renewal date, or upon the expiration of the
5 33 applicable collective bargaining contract, if any,
5 34 whichever is the later. This paragraph does not apply
5 35 to enrollees eligible for coverage under Title XVIII
5 36 of the Social Security Act, or any other similar

5 37 coverage under a state or federal government plan.
5 38 d. The health care services available to enrollees
5 39 under prepaid group plans covering hospital, medical,
5 40 or surgical expenses, may include, at the option of
5 41 the employer purchaser, a provision for payment of
5 42 covered services determined to be medically necessary
5 43 provided by a certified registered nurse certified by
5 44 a national certifying organization, which organization
5 45 shall be identified by the Iowa board of nursing
5 46 pursuant to rules adopted by the board, if the
5 47 services are within the practice of the profession of
5 48 a registered nurse as that practice is defined in
5 49 section 152.1, under terms and conditions agreed upon
5 50 between the employer purchaser and the health
6 1 maintenance organization, subject to utilization
6 2 controls. Additionally, any covered services provided
6 3 by a registered nurse shall be compensated at the same
6 4 level as equivalent services provided by a person
6 5 licensed in the practice of medicine or surgery under
6 6 chapter 148 or 150A. This paragraph shall not require
6 7 payment for nursing services provided by a certified
6 8 registered nurse practicing in a hospital, nursing
6 9 facility, health care institution, a physician's
6 10 office, or other noninstitutional setting if the
6 11 certified registered nurse is an employee of the
6 12 hospital, nursing facility, health care institution,
6 13 physician, or other health care facility or health
6 14 care provider. This paragraph applies to services
6 15 provided under plans within this state made on or
6 16 after July 1, 1989, and to existing group plans on
6 17 their next anniversary or renewal date, or upon the
6 18 expiration of the applicable collective bargaining
6 19 contract, if any, whichever is later. This paragraph
6 20 does not apply to enrollees eligible for coverage
6 21 under an individual contract or coverage designed only
6 22 for issuance to enrollees eligible for coverage under
6 23 Title XVIII of the federal Social Security Act, or
6 24 under coverage which is rated on a community basis, or
6 25 any other similar coverage under a state or federal
6 26 government plan.

6 27 Sec. _____. Section 514B.1, subsection 5, Code 2003,
6 28 is amended by adding the following new paragraph:

6 29 NEW PARAGRAPH. e. The health care services
6 30 available to enrollees under prepaid group plans
6 31 covering hospital, medical, or surgical expenses shall
6 32 include a provision for payment of necessary medical
6 33 or surgical care and treatment as well as drug
6 34 prescriptions provided by a podiatric physician
6 35 licensed under chapter 149, if performed within the
6 36 scope of the podiatrist's license and the plan would
6 37 pay for the care and treatment when the care and
6 38 treatment were provided by a person engaged in the
6 39 practice of medicine or surgery as licensed under
6 40 chapter 148 or 150A. Additionally, any medical or
6 41 surgical service provided by a podiatrist shall be
6 42 compensated at the same level as equivalent services
6 43 provided by a person licensed in the practice of
6 44 medicine or surgery under chapter 148, 149, or 150A.
6 45 The plan shall provide that the plan enrollees may
6 46 reject the coverage for services which may be provided
6 47 by a podiatric physician if the coverage is rejected
6 48 for all providers of similar services as licensed
6 49 under chapter 148, 149, or 150A. This paragraph
6 50 applies to services provided under plans made on or
7 1 after July 1, 2003, and to existing group plans on
7 2 their next anniversary or renewal date, or upon the
7 3 expiration of the applicable collective bargaining
7 4 contract, if any, whichever is the later. This
7 5 paragraph does not apply to enrollees eligible for
7 6 coverage under Title XVIII of the federal Social
7 7 Security Act or any other similar coverage under a
7 8 state or federal government plan.>

7 9 #2. By renumbering as necessary.

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